Chicago Benefits Office

Authorization Form For the Use and Disclosure of Protected Health Information

Patient's Name _____ **City Employee Name** _____

Patient's date of birth: _____ **City Employee ID# (optional):** _____

By signing this Authorization Form, I understand that I am authorizing the Chicago Benefits Office to use and disclose my protected health information (PHI), as described in more detail below, to the following person(s) or organization(s):

Name of person(s) or organization(s): _____

_____

Telephone Number: _____/_____/_____ Fax Number *(optional)*: _____/_____/_____

I authorize the use and disclosure of the following PHI (check all that apply):

□ Enrollment / Disenrollment Information

□ Other information *(describe)*: _____ _____ _____

for the following *(check all that apply)*: □ Myself. □ My dependent: *(print name(s))*: _____

_____ _____ _____ _____

This authorization shall not expire unless revoked.

I may revoke this authorization at any time by notifying the Chicago Benefits Office in writing. However, I understand that such a revocation will not have any effect on any information already used or disclosed before the Chicago Benefits Office received the written notice of revocation.

I understand that there is a potential that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and will no longer be protected by the Health Insurance Portability and Accountability Act.

This Authorization is voluntary and I may refuse to sign this Authorization form.

I understand that the Chicago Benefits Office may not condition payment, enrollment or eligibility for benefits on whether I sign this authorization, unless the authorization is requested prior to enrollment and is sought for eligibility or enrollment determinations or for underwriting or risk rating determination.

I understand that I have a right to inspect and copy the information for which I am authorizing disclosure.

I understand that I have the right to be provided with a copy of this signed authorization form.

_____ _____

Signature of patient / claimant/personal representative / child's parent **Printed name of person signing**

Date: _____/ _____/ _____

_____

Relationship to patient (if not signed by patient)